American Recovery and Reinvestment Act (ARRA):

Health Related Provisions

Description	Total Federal Spending (in millions)
Temporary Increase in Federal Medicaid Matching Funds Through FMAP - The across-the-board increase in FMAP would be 6.2%. The reductions in state share for states with increases in unemployment rates would be 5.5%, 8.5%, and 11.5%. These percent reductions would be applied against the state share after the hold harmless reduction and after an across-the board increase of 3.1%. California would receive an 11.59% FMAP increase; 6.2% general increase + 5.39% increase for unemployment. CA must change the semi-annual eligibility verification requirement for Medi-Cal in order to receive these funds.	$87,000
Extension of Qualified Individual (QI) Program - Extends program one year through December 31, 2010. Qualified individuals have incomes that are between 120 and 135 percent of the federal poverty level and are not otherwise eligible for Medicaid. The QI program is currently slated to end December 2009. This provision would provide additional funding available January 1, 2010 thru December 31, 2010.	($563)
Disproportionate Share Hospital (DSH) Increase - Provides for a temporary increase in the state DSH allotments during the recession period (FY 2009 and FY 2010) by 2.5%.	(Unknown)
Transitional Medical Assistance (TMA) - Extends program until 12/31/2010. States have options: to change the initial 6 months to 12 months and waive the requirement that beneficiaries have to have received Medicaid in at least 3 of the last 6 months period to qualify.	(Unknown)
Eligibility Determinations under Medicaid and CHIP for Indians - exempts 4 classes of property from resources in Eligibility Determinations under Medicaid and CHIP for Indians.	(Unknown)
Medicaid and CHIP Rules with Respect to Indian Enrollees, Indian Health Care Providers and Indian Managed Care Entities (MCE) - Requires that Indians enrolled in a non-Indian Medicaid MCE be allowed to choose an Indian provider as their primary care provider within the plan network when the Indian enrollee is otherwise eligible to receive services from the provider and the Indian provider has the capacity to provide the primary care services.	(Unknown)
COBRA Health Insurance Coverage - Temporary expansion of COBRA health insurance benefits to workers involuntarily separated from employment that provided health insurance benefits. The federal government would subsidize a share of the premium costs for those effected.	$24,700

American Recovery and Reinvestment Act (ARRA):

Health Related Provisions

Description	Total Federal Spending (in millions)
Health Information Technology for Economic and Clinical Health Act ("HITECH ACT") - Invests in health information technology (HIT) infrastructure and Medicare and Medicaid incentives to encourage providers to use HIT and electronic health information exchange.	$19,000
National Institutes of Health (NIH) Research Grants - Provides additional funding for biomedical research; the majority of funds are dedicated to new grants submitted by university scientists.	$10,000
Department of Health and Human Services (DHHS) Research Grants - Provides additional funding to the Office of the Director to support additional scientific research.	$7,400
Community Health Centers (CHCs) - HHS will receive $2 billion for federally qualified health centers (FQHCs), primarily CHCs, including $1.5 billion for construction, modernization and health information technology improvements and $500 million for FQHC grant funding for services and operations.	$2,000
Prevention and Wellness Fund - Provides additional funding to the Centers for Disease Control (CDC) for a myriad or health related prevention programs.	$1,100
Agency for Healthcare Research and Quality Grants - Provides funding to support comparative-effectiveness research to evaluate the relative effectiveness of medications and medical devices.	$1,100
Healthcare Workforce Development - Allocation to address health professions workforce shortages; $75 million for the National Health Service Corps will remain available through September 30, 2011. Funds may be used to provide scholarships, loan repayment, and grants to training programs or equipment.	$500

Adapted from information provided by the California Health and Human Services Agency and other sources, 3/2/09.

The American Recovery and Reinvestment Act of 2009:
A Guide for State and Local Governments

Prepared for The Council of State Governments by:
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**Admitted only in Texas; DC bar application pending. Supervised by principals of Latham & Watkins.*

Introduction

President Obama signed the American Recovery and Reinvestment Act of 2009 (the ARRA) into law on February 17, 2009, advancing an ambitious plan to revitalize the nation's economy. This $787 billion package seeks to stimulate economic growth through federal spending on such programs as education, energy, health care, housing, and transportation.

The ARRA provides funds for a wide array of public and private actors, including federal entities. This paper summarizes key opportunities for state, local, territorial, and tribal governments to secure federal support through the ARRA. This includes direct funding as well as opportunities to act as a conduit for funds to constituents. Many of the provisions in the ARRA increase funding for existing programs. This paper summarizes current law where appropriate, but assumes familiarity with such existing programs.

This paper is not intended as a comprehensive guide to any particular program, but is intended as a general summary of the law to help identify funding opportunities for further inquiry. Any organization or entity interested in a specific program or opportunity referenced in this paper should seek additional information from the relevant government agencies, and consult with competent counsel to determine applicable legal requirements in a specific situation.

Time is an important consideration in evaluating opportunities under the ARRA. By 45 days after the date of enactment (April 3, 2009), state governors (or in some cases, state legislatures) must certify that their states will request and use funds and that these activities will create jobs and economic growth. The ARRA emphasizes rapid expenditure by imposing deadlines for application and disbursement and granting priority to projects that can use funds quickly. Therefore, authorities that are able to take quick action will benefit most from the new funding. Any date contained in this paper is either explicitly set forth in the text of the ARRA or is calculated based on the number of calendar days from the enactment thereof. Dates determined by calculating the number of days from enactment of the ARRA are determined without regard to whether the date falls on a weekend or federal holiday and, therefore, are necessarily estimates. Legal counsel should be consulted to determine these dates with certainty.

Many provisions of the ARRA do not provide guidance on the distribution of funds provided therein. In the coming weeks, relevant government agencies will issue guidance regarding application and disbursement of funds under their jurisdiction.

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6. HEALTH CARE

A. Medicaid Provisions (State Fiscal Relief)

*State Fiscal Relief - **$87 billion***[1]
[B.V]

- **Temporary Increase in Federal Medical Assistance Percentage (FMAP)**. The ARRA increases the federal share of Medicaid payments in three ways. First, states are "held harmless" for any reductions in their FMAP that would have applied this year and through the first quarter of 2011 due to stronger economic conditions that may have prevailed in the state in past years. Second, the ARRA increases each state's FMAP by 6.2 percent through December 31, 2010. Third, states with increasing unemployment, determined on a quarterly basis, qualify for additional increases during the recession adjustment period (October 1, 2008, through December 31, 2010); any additional increase will remain in place at least through July 1, 2010.
  - States are not eligible for FMAP increases if (1) they have more restrictive Medicaid eligibility standards, methodologies, or procedures than those in place on July 1, 2008; (2) they have failed to make prompt payments; or (3) they attempt to hold onto any resulting state savings in a rainy day fund. If a state has restricted its Medicaid policies since July 1, 2008, it is eligible for an increased FMAP, retroactive to October 1, 2008, if it reinstates less restrictive policies by July 1, 2009. If a state reinstates less restrictive policies after July 1, 2009, it is eligible for an increased FMAP beginning with the first calendar quarter in which the less restrictive policies are reinstated. States that benefit from an increased FMAP are subject to certain reporting requirements and must submit a form regarding how funds were expended by September 30, 2011.
  - Note for local governments: If a state requires political subdivisions to contribute to the non-federal share of the state Medicaid plan, the state cannot require a greater percentage of the non-federal share than would have been required prior to the temporarily enhanced FMAP.
  - Note for territories: Each territory can select, via a one-time special election, a 6.2 percent increase in its FMAP and a 15 percent increase in its spending cap; otherwise it will be granted a 30 percent increase in its spending cap.
- **Temporary Increase in Disproportionate Share Hospital (DSH) Allotments**. The ARRA provides for a temporary increase in the DSH allotment for each state. For FY 2009, this provision will increase DSH allotments by 2.5 percent above the allotments states would have received under preexisting law. States' DSH allotments in FY 2010 will be equal to the FY 2009 allotments further increased by 2.5 percent. These increases will only apply if the state would not receive a larger increase under preexisting law. DHS allotments for FY 2011 and beyond will be calculated without regard to the temporary increases.
- **Extension of Transitional Medical Assistance (TMA)**. The ARRA provides for an eighteen-month extension of work-related TMA (through December 31, 2010). States may use a 12-month, rather than 6-month, initial extension period for families transitioning from welfare to work (in which case the additional 6-month extension no longer applies). States may also grant extensions to families that have received such aid for less than three months. States are subject to statistical reporting requirements, with reports due to HHS.

[1] Based on estimates from the Government Accountability Office and the Center on Budget and Policy Priorities.

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- **Extension of the Qualifying Individual Program**. The ARRA provides a for a one-year extension of the qualifying individual program (through December 2010) with an allocation of $412.5 million for the period between January 1, 2010 and September 30, 2010 and $150 million for the period between October 1, 2010 and December 31, 2010.

- **Indian Medicare and Medicaid Provisions**. The ARRA eliminates premiums, cost sharing, co-payments and similar charges for Indians who receive treatment from the Indian Health Service, an Indian Tribe, a Tribal Organization, an Urban Indian Organization, or a health care provider through referral under the contract health services program. Medicaid payments to those organizations will not be reduced by any amount that would be due from an Indian, if such charges were permitted. Furthermore, with respect to Indians, the ARRA exempts certain property for Medicaid eligibility determinations, protects tribal property from Medicaid estate recovery, and sets forth rules to provide access to Indian primary care providers and assure payment to Indian health care providers.

B. Electronic Health Record (EHR) Technology

Incentives for Providers to Adopt EHR Technology - ***$63,750 (per Medicaid Provider)***
[B.IV]

- Under the ARRA, the federal government will provide contributions for amounts states pay to eligible Medicaid providers to encourage the adoption of EHR technology, in order to promote health care quality and the exchange of health care information. The contributions can be as much as $21,250 per provider for the first year of payments (which may not be later than 2016), and as much as $8,500 for up to five years thereafter. Providers eligible for both Medicare and Medicaid incentive payments are required to choose one.

- Eligible providers include physicians, nurses and midwife nurses who are not hospital based and whose patient volume is at least 30 percent attributable to Medicare. Such providers are eligible for payment of up to 85 percent of their net allowable technology costs, up to the maximum and subject to specified annual limits. Acute care hospitals with Medicaid patient volume of 10 percent or more and children's hospitals with any Medicaid volume are also eligible. Payments to hospitals are limited to amounts analogous to those specified for Medicare hospitals in § 4312 of the Act.

- In order to be eligible for federal contributions, states must provide assurances that the amounts are paid directly to Medicaid providers without deductions or rebates. States may receive contributions for the administrative costs of making payments to encourage the use of certified EHR technology. Additionally, the state must conduct adequate oversight of its EHR technology encouragement program.

Incentives for Hospitals to adopt EHR Technology - ***Variable Amount (per Hospital)***
[B.IV]

- The ARRA provides funding for hospitals that are "meaningful users" of EHR technology, as defined by the ARRA. The hospital must demonstrate (via attestation, claim submission, survey, or other method specified by the Secretary) that meaningful EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care coordination. Information relating to clinical quality measures must be submitted in a form and manner specified by the Secretary.

- The amount of federal funding for each hospital using EHR technology is determined by a formula contained in Section 4102(a)(1) of the ARRA, with a base amount of $2 million. Critical Access Hospitals may receive additional EHR technology-related payments under Section 4102(a)(2) of the ARRA.

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C. National Coordinator for Health Information Technology

Grants to the Office of the National Coordinator for Health Information Technology - ***$2 billion***
[A.VIII]

- The ARRA allocates $2 billion to the Department of Health and Human Services's Office of the National Coordinator for Health Information Technology (ONCHIT) for efforts to create a national medical record database. Of this allocation, **$300 million** is designated for "regional or sub-national efforts" toward health information exchange.

Immediate Funding to Strengthen the Health Information Technology Infrastructure - ***At least $300 million***
[A.XIII]

- The ARRA requires the Secretary of Health and Human Services (HHS Secretary) to promote the use and exchange of electronic health information (HIT). Funds are to be administered through federal agencies with expertise to support the following: (1) HIT architecture to support the secure electronic exchange of information; (2) electronic health records for providers not eligible for HIT incentive payments under Medicare and Medicaid; (3) training and dissemination of information on best practices to integrate HIT into health care delivery; (4) telemedicine; (5) interoperable clinical data repositories; (6) technologies and best practices for protecting health information; and (7) HIT use by public health departments.
- The HHS Secretary is required to invest $300 million to support regional health information exchanges, and may use funds to carry out other authorized activities.

Health Information Technology Implementation Assistance
[A.XIII]

- The ARRA requires the HHS Secretary, acting through the National Coordinator for HIT, in consultation with NIST and other agencies, to establish an HIT extension program to assist providers in adopting and using certified electronic health resource technology. The Secretary is also required to support HIT Regional Extension Centers affiliated with non-profit organizations to provide assistance to providers in the region. The Secretary is required to give priority to public, non-profit, and critical access hospitals, community health centers, individual and small group practices, and entities that serve the uninsured, underinsured and medically underserved individuals. Funded entities may receive up to four years of funding to cover up to 50 percent of their capital and annual operating and maintenance expenditures.
- The HHS Secretary is required to publish a notice describing the program and the availability of funds within 90 days of the date of enactment (by May 18, 2009). Each regional center receiving funding would be required to submit to a biennial evaluation of its performance against specified objectives, and continued funding after two years is contingent on receiving a positive evaluation. The HHS Secretary may require an annual report. An annual review by the National Coordinator for HIT is required.

State Grants to Promote Health Information Technology
[A.XIII]

- The National Coordinator for HIT is authorized to award planning and implementation grants to states or qualified state-designated entities to facilitate and expand electronic health information exchange.
- The state or state-designated entity (as defined under § 3013(f) of the Public Health Service Act) must submit a plan describing the activities to be carried out to facilitate HIT exchange. States must contribute a certain portion of matching funds after FY 2011 and

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the HHS Secretary has the discretion to require such matching funds before then. The Secretary may require annual reports. An annual review by the National Coordinator for HIT is required.

Competitive Grants to States and Indian Tribes for the Development of Loan Programs to Facilitate the Widespread Adoption of Certified EHR Technology
[A.XIII]

- The National Coordinator for HIT is authorized to award competitive grants to states and Indian tribes to establish loan programs for health care providers to purchase EHR technology, train personnel in the use of that technology and improve the secure exchange of health information. Grantees would be required to (1) establish a qualified HIT loan fund, (2) submit a strategic plan, updated annually, that describes the intended uses of the funds and provides assurances of their proper use by health care providers, and (3) provide matching funds (at least $1 for every $5 of federal funds).
- No awards are permitted under this subsection before January 1, 2010. The HHS Secretary may require an annual report. An annual review by National Coordinator for HIT is required.

Demonstration Program to Integrate Information Technology Into Clinical Education
[A.XIII]

- The ARRA authorizes the HHS Secretary to award competitive grants to graduate health education programs to integrate HIT into the clinical education curriculum. Grantees must submit a strategic plan. The grant cannot cover more than 50 percent of the costs of any assisted activity (absent a waiver). The HHS Secretary may require an annual report. An annual review by the National Coordinator for HIT is required.

Information Technology Professionals in Health Care
[A.XIII]

- The ARRA requires the HHS Secretary to provide financial assistance to universities to establish or expand medical informatics programs, in consultation with the Director of the National Science Foundation. Such grants cannot cover more than 50 percent of the costs of any assisted activity (absent a waiver). The HHS Secretary may require an annual report. An annual review by the National Coordinator for HIT is required.

D. National Institute of Standards and Technology

Research and Development Programs
[A.XIII]

- The ARRA requires the National Institute of Standards and Technology (NIST), in consultation with the National Science Foundation (NSF) and other federal agencies, to award competitive grants to universities or research consortia for establishing multidisciplinary Centers for Health Care Information Enterprise Integration. The Centers are to generate innovative approaches to the development of a fully interoperable national health care infrastructure, as well as develop and use HIT.
- Grants are to be awarded on a "merit-reviewed, competitive basis." The NIST Director will establish rules governing submission of applications, which must, at minimum, describe the proposed Center's research projects, how the Center will promote interdisciplinary collaboration, technology transfer activities to diffuse research results, and how the Center will contribute to education and training.

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E. Other Health Care Provisions

Prevention and Wellness Fund Grants - ***$1 billion***
[A.VIII]

- The ARRA provides $50 million to the Department of Health and Human Services to award grants to the states for infectious disease reduction strategies.
- Furthermore, the ARRA provides $650 million to the Centers for Disease Control (CDC) to develop "community-based" prevention and wellness strategies to address chronic disease rates, that may benefit state and local governments.
- The ARRA provides $300 million to the CDC to administer an immunization program in partnership with health care providers in the public and private sectors, including state and local health departments and clinics. *See* Public Health Service Act, § 317, 42 U.S.C. § 247(b).

National Center for Research Resources - ***$1 billion***
[A.VIII]

- *See* Technology and Science.

Construction of State Extended Care Facilities - ***$150 million***
[A.X]

- *See* National Guard and Veterans.

Rural Community Facilities Program - ***$130 million***
[A.I]

- *See* Law Enforcement and Community Services.

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